

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>WILLIAM PARKS PARKS ABBOTT, Sr.</b>		2a DATE OF DEATH MONTH DAY YEAR <b>10 - 6 87</b>		2b HOUR <b>3:20 AM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>08 06 02</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b>	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>
7b CITIZEN OF WHAT COUNTRY? <b>US</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>		10 CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CAMBRIDGE House Nursing Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waterman</b>	12b KIND OF BUSINESS OR INDUSTRY <b>shellfish</b>	
13a STATE <b>MD.</b>	13b COUNTY <b>Dorchester</b>	13c CITY OR TOWN <b>Toddville</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>Box 232 21672</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES GEORGE ABBOTT</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOLA HURLEY</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-10-0545</b>	17 INFORMANT <b>wife</b> ADDRESS <b>Monnie M. Abbott, same as 13e</b>		

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>SVA 2 hemiparesis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myopericardial cardiovascular disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Severe disorder, COPD</b>				
19a DATE OF OPERATION <b>9-29-87</b>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from <b>1986</b> , 19____, to <b>10-6</b> 19 <b>87</b> that (1) (we) last saw the deceased alive on <b>9-29-87</b> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.				
22b SIGNATURE <b>Michael J. Fadden</b>		DEGREE <b>MD</b>		22c DATE SIGNED
22b PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael J. Fadden MD</b>		22c ADDRESS <b>308 Collins, Hurdock Md 21643</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b DATE <b>10/8/87</b>	23c NAME OF CEMETERY OR CREMATORY <b>Wesley Church Cem.</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Andrews, Dorchester, Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Curran Funeral Home, 308 High St. Cambridge, Md. 21613</b>		25a DATE REC'D. BY REGISTRAR <b>OCT 09 1987</b>		
		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8578 OCT 13 01

20% COTTON FIBER

REFINED POWD

Made

White

of 22

Decorated

Cambridge

Cambridge House Building

Mr. Cambridge Building

Cambridge

Cambridge

10-10-1958

OCT 09 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOTTIE ELOISE BRADSHAW			2a DATE OF DEATH MONTH DAY YEAR Oct 13 1987			2b HOUR 12:50 AM	
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Sept 2, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 82	7 UNDER YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD			
10 CITY OR TOWN OF DEATH Cambridge	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a STATE MD.	13b COUNTY Dor.	13c CITY OR TOWN Church Creek	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE St. Rt. 335 21622			
14 FATHER'S NAME FIRST MIDDLE LAST Crisfield Elzey		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Lord					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 212-40-7650		17 INFORMANT ADDRESS Box 632 Church Creek Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>YEARS</u> <u>YEARS</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (a) this hospital attended the deceased from <u>1983</u> 19 <u>Oct 13</u> 19 <u>87</u> that (b) I saw the deceased alive on <u>Oct 13</u> 19 <u>87</u> and that in my (c) (four) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) did not view the body after death.							
22b SIGNATURE Michael A. Moskewicz				DEGREE MD		22c DATE SIGNED Oct 13 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD				22e ADDRESS 503 34th ST. CAMBRIDGE MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE 10/15/87		23c NAME OF CEMETERY OR CREMATORY St. Johns Churchyard		23d LOCATION CITY OR TOWN COUNTY STATE Golden Hill Dor. Md.	
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 22 1987 Julia Davidson			

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

000284 001300 3-7702 00000000

10/10/77

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10/10/77

070494 NOV-21 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Coleman Wheatley Cook</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 24 87</b>			2b HOUR <b>1:20 PM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 30, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co. MD</b>				
10 CITY OR TOWN OF DEATH <b>Cambridge</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bricklayer</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Maryland</b>			13b COUNTY <b>Dorchester</b>		13c CITY OR TOWN <b>Cambridge</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>Rt 1 Box 162 21613</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Herman G. Cook</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Arthur Agnes Wheatley</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO <b>214-07-7305</b>		17 INFORMANT ADDRESS <b>Louise Windsor Item # 13</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									(b) <b>Possible ruptured abd. aneurysm</b>	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>ASCVD</b>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>19</b>			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (1) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Thomas Coleman</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>10/27/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>Dor. Mem. Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dor. Md.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE, MD.</b>						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE <b>Julia Denton-Rudolph</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

070184 NW-867

5-1-58 14 31

Colman Rd

White 21 20 81

PAUL HOLLON NO. 1

070184

070184 NW-867

OCT 30 NW 14 31

069877 OCT 27 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29599

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH			MONTH DAY YEAR			HOUR			
MICHAEL EVAN			Daringer			DATE ESTI MATED			10 11 19 87			M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD		2d HOUR	
male		white		07/15/1960		27 YRS		MONTHS DAYS		HOURS MIN		10 18 19 87		2:30 P M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
N.Y.				U.S.A.								Dorchester County MD			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY			
Golden Hill				woods off Oldfield Rd.											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MD.				Dor.				Cambridge				Rt. 4 Box 192 21613			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST						FIRST MIDDLE LAST									
Ronald G. Daringer						Dolores Anderson									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS			
Yes				1986-1987				219-70-8319				Ronald G. Daringer Item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound of neck</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
				est. year HOUR A.M. MONTH DAY P.M. 10 11 19 87				self inflicted							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME STREET FACTORY FARM ETC.)				21f LOCATION							
				woods				off Oldfield Rd, Golden Hill, Dorchester, MD.							
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
<i>Mario F. Golle, Jr.</i>				Assistant				10/19/87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Mario F. Golle, Jr., M.D.				111 Penn St.				Balto., MD.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION					
cremation				10/20/87		Loudon Park Cem.				Baltimore Md.					
24 FUNERAL DIRECTOR						25a DATE REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
THOMAS FUNERAL HOME CAMBRIDGE MD.															

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 BP  
25M  
DHMH - 17  
(VR A15 ME (5))

101513 573880

101513



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. The funeral director should also complete the space for carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

29000

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (PRINT) <b>Stella Johnson Dean</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Oct 14 1987</b>		2b HOUR <b>11:05 PM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>October 14, 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	IF UNDER 1 YEAR MONTHS DATE HOUR MIN <b>YRS</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>US</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co. MD</b>	
10 CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cambridge House</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker.</b>		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Dorchester</b> 13c CITY OR TOWN <b>Cambridge</b>		13d INSIDE CITY LIMITS? <b>YES XX NO <input type="checkbox"/></b>		13e STREET ADDRESS / ZIP CODE <b>520 Glenburn Ave. 21613</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Aaron Johnson</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vertie Robinson</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>216-48-6064</b>		17 INFORMANT ADDRESS <b>Annapolis, Md. 21401</b> <b>Diane Bartz 109 Simms Dr.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>8/19/86</b> to <b>10/14/87</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Mary Ann D. Moore MD</b>		DEGREE		22c DATE SIGNED <b>10/14/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mary Ann D. Moore MD</b>		22e ADDRESS <b>404 Byrn St, Cambridge, MD 21613</b>			
23a BURIAL, CREMATION, REMOVAL (CHECK BY) <b>Burial</b>		23b DATE <b>10/18/87</b>	23c NAME OF CEMETERY OR CREMATORY <b>Dor. Mem. Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor Md.</b>
24 FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE, MD.</b>			25a DATE REC'D BY REGISTRAR <b>OCT 22 1987</b>		

25b REGISTRAR'S SIGNATURE  
*[Signature]*

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60% COTTON FIBER

100% COTTON

100% COTTON

OCT 28 1985

070365 NOV-287

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO.

29001

1 DECEASED NAME (TYPE OR PRINT) <b>Robert Emmett DEWLIN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 26 87</b>			2b HOUR <b>11 P.M.</b>			
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>2 24 20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co. MD</b>			
10 CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Surveyor</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Dorchester</b> 13c CITY OR TOWN <b>Cambridge</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>Rt 3 Box 219 21613</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Mason Dewlin</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hester Ann Roach</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>		16b SOCIAL SECURITY NO <b>219-07-4289</b>		17 INFORMANT ADDRESS <b>Ruth S. Dewlin Item # 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ca of lung</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary A. Disease</b>									
19a DATE OF OPERATION <b>10/29/87</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>19</b>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Thomas</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>10-27-87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>10/29/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>Dor Mem Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor Md.</b>			
24 FUNERAL DIRECTOR (NAME) <b>THOMAS FUNERAL HOME CAMBRIDGE, MD.</b>				25a DATE REC'D. BY REGISTRAR <b>Oct 30 1987</b>					
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William Ellsworth Dietrich</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10/5/87</i>			2b. HOUR <i>2348</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 6, 1919</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester Co.</i> MD			
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Rt 1 Box 238 EE 21613</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin Franklin Dietrich</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Mae Riley</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-07-7872</i>		17. INFORMANT ADDRESS <i>Pauline J. Dietrich Item # 13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastric Lymphoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CME of ASHD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>for Pulm Embolism</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>									
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>— — — — —</i>					
22a. I certify that (s) (this hospital) attended the deceased from <i>9/18</i> 19 <i>87</i> to <i>10/5</i> 19 <i>87</i> that (s) (we) last saw the deceased alive on <i>10/5</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Vinodrai Mehta</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>10/6/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VINODRAI MEHTA</i>				22e. ADDRESS <i>400 AURORA ST. CAMBRIDGE MD 21613</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/8/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dor Mem Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cambridge Dor Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>THOMAS FUNERAL HOME CAMBRIDGE, MD.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 09 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John E. ...</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BRICE E Johnson</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 25 87</b>		2b HOUR <b>8:00 AM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>6 10 99</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE COUNTRY <b>MD.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD	
10 CITY OR TOWN OF DEATH <b>Bishops Head</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>at home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waterman</b>		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>			13b COUNTY <b>Dor.</b>		13c CITY OR TOWN <b>Bishops Head</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Goldsborough Johnson</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Ruark</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO <b>217-16-9270</b>		17 INFORMANT ADDRESS <b>Phyllis J. Mills Box 35 Bishops Head Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ruptured aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <b>87/10/21</b> 19 <b>87</b> to <b>10/25</b> 19 <b>87</b> that (2) I saw the deceased alive on <b>10/25</b> 19 <b>87</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.					
22b SIGNATURE <b>Maydon D. Moore</b>		DEGREE		22c DATE SIGNED <b>10/25/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b DATE <b>10/27/87</b>	23c NAME OF CEMETERY OR CREMATORY <b>DOR. MEMORIAL PK.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>CAMBRIDGE, DOR., MD.</b>
24 FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>			25a DATE REC'D BY REGISTRAR <b>OCT 30 1987</b>		
ADDRESS <b>CAMBRIDGE MD.</b>			25b REGISTRAR'S SIGNATURE <b>Julia Swinson-Randee</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print)		First <b>EMMA</b>	Middle	Lost <b>KEENE</b>	2a. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>87</b>		2b. HOUR M	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH <b>12/22/1924</b>		6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester Co.</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dorchester Gen</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>labor</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>614 Bradley Avenue</b>
14. FATHER'S NAME First <b>William</b>		Middle <b>Kid</b>		Last <b>Nelson</b>		15. MOTHER'S MAIDEN NAME First <b>Loaise</b>		Middle <b>Nichols</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>218-16-7535</b>		17. INFORMANT <b>Fannie Stevens</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETES complicated by Cardio-</b> DUE TO, OR AS A CONSEQUENCE OF <b>Vascular Dis.</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Michael Joyce M.D.</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/30/87</b>
22d. PHYSICIAN'S NAME (Type) <b>DR. MICHAEL JOYCE M.D.</b>				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/31/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>V. A. Cone</b>		23d. LOCATION (City or Town) (County) (State) <b>Harlock Don Md.</b>		
24. FUNERAL DIRECTOR <b>Stewart Fun Home</b>				ADDRESS <b>Camd, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 03 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10-16-87</b>			2b. HOUR <b>11:15</b> M		
3. SEX <b>M</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-7-30</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>57</b> YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c. DATE PRONOUNCED DEAD <b>10-17-87</b>	7d. HOUR <b>12:17</b> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD		
10. CITY OR TOWN OF DEATH <b>DANBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PUMP CO.</b>
13a. STATE <b>MD</b> 13b. COUNTY <b>DORCHESTER</b> 13c. CITY OR TOWN <b>PASADENA</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>1336 EDNA RD. 21122</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA WHITE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>218-26-4407</b>			17. INFORMANT ADDRESS <b>HOSPITAL RECORDS DORCHESTER GEN HOSP</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 HOURS</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>IDIOPATHIC HYPERTROPHIC SUBAORTIC STENOSIS</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE (NATURE OF INJURY) <b>UNDERLYING DISEASE CONTRIBUTING TO CAUSE OF DEATH</b>			21b. TIME OF INJURY HOUR A.M. MINUTE P.M. <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>N/A</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (STREET, RAILROAD, PARK, ETC.) <b>N/A</b>		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>N/A</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Donald R. Swellman</b>			TITLE (SPECIFY) <b>DEPUTY</b>			MEDICAL EXAMINER DATE SIGNED <b>10/17/87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>DONALD R. SWELLMAN MD</b>			ADDRESS <b>308 GAY ST. CAMBRIDGE, MD 21613</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>OCT. 21, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PARK</b>		23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>KERRIDGE HOWARD MD</b>		
24. FUNERAL DIRECTOR NAME <b>McCULLY FUNERAL HOMES</b>			ADDRESS <b>3204 MOUNTAIN RD PASADENA, MD 21122</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DISEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Joseph Thomas Moore

2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR 10 25 87 25 AM

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

9 11 38

6 AGE (IN YEARS)

49 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7c. DATE PRONOUNCED DEAD

10 25 87 9 25 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

Dorchester County MD

10 CITY OR TOWN OF DEATH

Cambridge

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Dorchester General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Computer Operator

12b. KIND OF BUSINESS OR INDUSTRY

Banking

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md.

13b. COUNTY

13c. CITY OR TOWN Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 816 Shore Street 21225

14. FATHER'S NAME

First Jay

Middle M.

Last Moore

15 MOTHER'S MAIDEN NAME

First Gloria

Middle I.

Last Gillespie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

1957-1959

218-34-0326

17 INFORMANT

Gloria I. Beth 7733 Telegraph Rd #40

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

Myocardial infarction  
Severe Coronary sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

19c. AUTOPSY?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21a. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21c. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Peter W. Rieckert

TITLE (SPECIFY)

Deputy

M.D. MEDICAL EXAMINER

DATE SIGNED 10-25-87

EXAMINER'S NAME (TYPE OR PRINT)

Peter W. Rieckert

ADDRESS

E. New Market, MD 21631

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10/29/87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION

Baltimore

COUNTY A.A.

STATE Md

24. FUNERAL DIRECTOR

George J. Gonce 4001 Ritchie Hwy Balto Md

25a. DATE REC'D. BY REGISTRAR

OCT 26 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Randall

145370370830

100% COTTON 2 REELS

100% COTTON 2 REELS



145370370830

068756 OCT 16 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) LOIS WINFIELD MURPHY		2a DATE OF DEATH MONTH DAY YEAR Oct. 8, 1987		2b HOUR 10:20 P. M.
3 SEX male	4 RACE Caul	5 DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD
10 CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN	12b KIND OF BUSINESS OR INDUSTRY SHELLFISH
13a STATE MARYLAND		13b COUNTY DORCHESTER	13c STREET ADDRESS / ZIP CODE BISHOP'S HEAD, MD GENERAL DELIVERY, 21611	
14 FATHER'S NAME FIRST MIDDLE LAST WINFIELD P. MURPHY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLENNIE F. MURPHY		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 220-18-3581		17 INFORMANT wife ADDRESS MRS. DORA P. MURPHY, same as 13e
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Dehydration, atrial fibrillation, Progressive dementia</u>				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (1) (this hospital) attended the deceased from <u>10/5</u> 19 <u>87</u> to <u>10/8</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>10/8</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.				
22b SIGNATURE <u>Hubert L. Ferry</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/8/87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT L. FERRY</u>		22e ADDRESS <u>503 BYRN ST</u>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE 10/11/87	23c NAME OF CEMETERY OR CREMATORY DORCHESTER MEM. PK. AIREY, DORCHESTER, MD.	
24 FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME 308 HIGH ST., CAMBRIDGE, MD. 21613		25a DATE REC'D. BY REGISTRAR OCT 15 1987		
		25b REGISTRAR'S SIGNATURE <u>Julie Davidson-Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then attach to the carbon copiers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

000120 OCT 1903



WINTERHILL

93813-101700 1903

OCT 15 1903

068203 OCT 13 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA E PARKS			2a DATE OF DEATH MONTH DAY YEAR 10/7/87		2b HOUR 12:20 AM
3 SEX Fe	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 4 10 94		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS	IF UNDER 1 YEAR MONTH DAY HOUR MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10 CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Md.	13b COUNTY Dor.	13c CITY OR TOWN Wingate	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE UNKNOWN 21675	
14 FATHER'S NAME FIRST MIDDLE LAST Asbury Levin Wingate		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Johnson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 218-34-8193		17 INFORMANT ADDRESS John Parks Cambridge Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } b) CAFE & HBP DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from 10/6 87 to 10/7 87 that (I) (we) last saw the deceased alive on 10/6 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Vinodrai Mehta		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/7/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) VINODRAI MEHTA		22e ADDRESS 400 Aurora St. Cambridge Md 21613.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b DATE 10/9/87	23c NAME OF CEMETERY OR CREMATORY DOR. MEM. PARK		23d LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DOR. MD.	
24 FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME CAMBRIDGE MD.		25a DATE REC'D. BY REGISTRAR OCT 09 1987			
		25b REGISTRAR'S SIGNATURE J. Davidson			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VRA 15, 4)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

29507

1 DECEASED NAME (TYPE OR PRINT) Wilsie R. Slacum				7a DATE OF DEATH MONTH DAY YEAR 10-22-87				7b HOUR 7:55 PM	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Oct 30 1913		6 AGE (IN YEARS LAST BIRTHDAY) 73		7c UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD			
10 CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.				13b COUNTY Dor.		13c CITY OR TOWN Cambridge		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Ernest Ruark				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Meddie James				13e STREET ADDRESS / ZIP CODE 325 Dorchester Ave. 21613	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 212-14-4210		17 INFORMANT Emerson B. Slacum				Item # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Lat Cell Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4d</u> <u>2 mos</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <u>SEP 30</u> 19 <u>87</u> to <u>10-22</u> 19 <u>87</u> that (1) we last saw the deceased alive on <u>10-22-87</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.)									
22b SIGNATURE <u>Craig W Caldwell</u>				DEGREE MD				22c DATE SIGNED 10-22-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) CRAIG W CALDWELL				22e ADDRESS DORCHESTER GENERAL HOSP CAMBRIDGE MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE 10/25/87		23c NAME OF CEMETERY OR CREMATORY E. NEW MARKET CEM.		23d LOCATION CITY OR TOWN COUNTY STATE E. NEW MARKET, DOR., MD.			
24 FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME CAMBRIDGE MD.				25a DATE REC'D. BY REGISTRAR OCT 30 1987					
				25b REGISTRAR'S SIGNATURE <u>Julia Benson-Budner</u>					

070008 101-201

RECEIVED OCT 30 1964

*[Faint, mostly illegible handwritten text on lined paper]*

RECEIVED OCT 30 1964

OCT 30 1964

068753 OCT 16 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

 1687  
 STATE  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Gladys G. Stevens</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10.12.87</b>				2b. HOUR <b>755A<sub>M</sub></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 06 09</b>		6. AGE IN YEARS, LAST BIRTHDAY <b>78</b>		7. UNDER 1 YEAR 8. UNDER 5 YEARS 9. UNDER 10 YEARS 10. UNDER 15 YEARS 11. UNDER 20 YEARS 12. UNDER 25 YEARS 13. UNDER 30 YEARS 14. UNDER 35 YEARS 15. UNDER 40 YEARS 16. UNDER 45 YEARS 17. UNDER 50 YEARS 18. UNDER 55 YEARS 19. UNDER 60 YEARS 20. UNDER 65 YEARS 21. UNDER 70 YEARS 22. UNDER 75 YEARS 23. UNDER 80 YEARS 24. UNDER 85 YEARS 25. UNDER 90 YEARS 26. UNDER 95 YEARS 27. UNDER 100 YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester MD.</b>			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Eastern Shore Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md. Cecil</b>		13b. CITY OR TOWN <b>North East</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>25 Rail Road Rd. 21901</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rastes Grimmit</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>235-28-5175</b>		17. INFORMANT ADDRESS <b>14 Elk Hill Ct. 21921</b>					
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Respiratory arrest</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last <b>Cardiac Congestion failure</b> DUE TO OR AS A CONSEQUENCE OF <b>Cardiac arrhythmia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>9/29/87</b> <b>4/20/87</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Hypertension, Diabetes, Arthritis</b>									
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>6-6-</b> 19 <b>85</b> to <b>10-12</b> 19 <b>87</b> that (1) (we) lost saw the deceased alive on <b>None</b> 19 <b>87</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>M.P.</b>				22c. DATE SIGNED <b>10/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-15-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>North East Meth.</b>		23d. LOCATION <b>North East Cecil Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>[Signature]</b>				DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>					

BP

 DHMH - 16 60M 7-84  
 (VRA 15, 4)

78 61 120 27 5 6 0 0

071266 NOV 9 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 60M 7-84  
(VIA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

FOR 1 - STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST LEO	MIDDLE LEWIS	LAST WANEX	2a. DATE OF DEATH MONTH DAY YEAR 10-17-87		2b. HOUR 254 M
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR NOVEMBER 15, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTH DAY HOUR MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY MD			
10 CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN/FARMER		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED			
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN EASTNEWMARKET		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE WARWICK ROAD/21631	
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTOINETTE (UNKNOWN)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -		16b. SOCIAL SECURITY NO 216-16-7308		17 INFORMANT RT. 1, BOX 180 ANNA LEE WANEX, EAST NEW MARKET, MD 21631	
MEDICAL CERTIFICATION		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRAIN DEATH</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSENITIC CARDIOVASCULAR DISEASE - SEVERE</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HRS (APPROX) 3 HRS (APPROX)	
		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACILITY, FARM, ETC.) N/A	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		22a. I certify that (I) (this hospital) attended the deceased from 10/17/87 to 10/17/87 that (I) (we) last saw the deceased alive on 10/17/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE DONALD R. McWILLIAMS M.D.		DEGREE M.D.		22c. DATE SIGNED 10-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. McWILLIAMS, M.D.		22e. ADDRESS 386 GAY STREET, CAMBRIDGE, MD 21613		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-20-87		23c. NAME OF CEMETERY OR CREMATORY OUR LADY OF GOOD COUNSEL, SECRETAY, DORCHESTER, MD	
24 FUNERAL DIRECTOR NAME ADDRESS ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631		25a. DATE REC'D. BY REGISTRAR NOV 6 1987		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84  
(VRA 15. 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Samuel L Wilder</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10-29-87</u>		2b. HOUR <u>833 PM</u>	
3. SEX <u>MALE</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>10 13 21</u>		
6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>South Carolina</u>		8. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u> MD		10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General</u>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>mainten</u>		13. STREET ADDRESS / ZIP CODE <u>614 Race St. Cambridge, Md. 21613</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Samuel Wilder</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Linda Davis</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		
16b. SOCIAL SECURITY NO. <u>1941-1943 249-126143</u>		17. INFORMANT <u>Donna Bohaker Cambridge, Md.</u>		ADDRESS <u>117 Talbot Ave.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Massive Hemoptysis</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Squamous cell carcinoma of the lung</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>30 minutes</u> <u>1 year</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from <u>Oct 29 1987</u> to <u>Oct 29 1987</u> that (1) (we) lost saw the deceased alive on <u>Oct 29 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Edmund J MacLaughlin</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>10/29/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edmund J MacLaughlin</u>		22e. ADDRESS <u>10 Aurora St. Cambridge, Md 21613</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11-3-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holling Green West Chester Pa.</u>		
23d. LOCATION (CITY OR TOWN) <u>West Chester Pa.</u>		24. FUNERAL DIRECTOR NAME <u>Bennie L. Smith</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 02 1987</u>		
25b. REGISTRAR'S SIGNATURE <u>Julia Swiden-Randall</u>		25c. REGISTRAR'S ADDRESS <u>P.O. Box 928 Md.</u>				

MEDICAL CERTIFICATION



X 3/21/88

071262 NOV - 9 87

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										29613	
1- STATE REGISTRAR										REG. NO.	
2a DECEASED NAME FIRST MIDDLE LAST <b>Arthur (NMI) Willey</b>										2b DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>10 16 87</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 17, 1919</b>		6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>68 YRS</b>		IF UNDER 1 YR MONTHS DAYS HOURS MIN.		7c DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 16 87</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b CITIZEN OF WHAT COUNTRY? <b>USA</b>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b>	
10 CITY OR TOWN OF DEATH <b>Cambridge</b>				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b KIND OF BUSINESS OR INDUSTRY <b>State Gov't</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE <b>Maryland</b>		13b COUNTY <b>Dorchester</b>		13c CITY OR TOWN <b>Secretary</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>Wes and Main Streets/21664</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Edward Willey</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Martin</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17 INFORMANT ADDRESS <b>P. O. Box 100</b> <b>Goldie Jane Ann Willey, East New Market MD</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST (b) <b>CARDIAC DYSRHYTHMIA OR</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE MYOCARDIAL INFARCTION</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>MINUTES</b> <b>MINUTES</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>N/A</b>											
19a DATE OF OPERATION <b>N/A</b>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>N/A</b>						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>N/A</b>				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N/A</b> 19		21c HOW INJURY OCCURRED, (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>N/A</b>					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <b>N/A</b>				21e PLACE OF INJURY STREET, FACTORY, <b>N/A</b> HOME		21f LOCATION STREET <b>N/A</b>		CITY OR TOWN <b>N/A</b>		COUNTY <b>N/A</b>	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Donald R. McWilliams</b>						TITLE (SPECIFY) <b>DEPUTY</b>		MEDICAL EXAMINER		DATE SIGNED <b>10-20-87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Donald R. McWilliams, M.D.</b>						ADDRESS <b>308 Gay Street, Cambridge, MD 21613</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b DATE <b>Oct 20, 1987</b>		23c NAME OF CEMETERY OR CREMATORY <b>MD Eastern Shore Vet. Cem., Beulah, Dorchester, MD</b>				23d LOCATION CITY OR TOWN <b>N/A</b>	
24 FUNERAL DIRECTOR NAME <b>Zeller Funeral Home, East New Market, MD</b>						25a DATE REC'D. BY REGISTRAR <b>NOV 6 1987</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

29614

1- FOR  
STATE  
REGISTRAR

1- DECEASED NAME (OR PRINT)		FIRST DORA		MIDDLE WASHINGTON		LAST WINGATE		2a DATE KNOWN OF DEATH ESTI MATED		MONTH 10-22		DAY 1987		YEAR 1987		2b HOUR 7:30 M							
3 SEX F		4 RACE C		5 DATE OF BIRTH MONTH 2-27-03		YEAR 84		6 AGE (IN YEARS) (LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD		MONTH 10-22		DAY 1987		YEAR 1987		2d HOUR 9:00 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD											
10 CITY OR TOWN OF DEATH HUDSON (NEAR)				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hudson Wharf Rd. (home)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b KIND OF BUSINESS OR INDUSTRY							
13a STATE MD				13b COUNTY DORCHESTER				13c CITY OR TOWN CAMBRIDGE				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET ADDRESS RFD #3 Box 229 HUDSON WHARF ROAD							
14 FATHER'S NAME FIRST AUGUSTUS				MIDDLE I				LAST RUARK				15 MOTHER'S MAIDEN NAME FIRST XXXXXXXX				MIDDLE IDA				LAST FAZIER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-7657				17a HOME ADDRESS MR. DUANE MARSHALL, 102 JOHNSON ST. XXXXXXXXXXXXXXXXXXXXXXXXXXXX CAMBRIDGE, MARYLAND 21613															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																							
PART I DEATH WAS CAUSED BY																							
IMMEDIATE CAUSE (a) CARDIAC ARREST																							
DUE TO, OR AS A CONSEQUENCE OF																							
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) CARDIAC DYSRHYTHMIA OR																							
DUE TO, OR AS A CONSEQUENCE OF																							
RECURRENT MYOCARDIAL INFARCTION																							
WITHIN MINUTES																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
DECEASED HAD AN ACUTE MYOCARDIAL INFARCTION ABOUT 1 MONTH AGO																							
19a DATE OF OPERATION N/A				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A										20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR <input checked="" type="checkbox"/> N/A CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A															
21d INJURY OCCURRED WHILE <input type="checkbox"/> N/A AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY STREET, FACTORY, FARM, ETC. N/A				21f LOCATION STREET CITY OR TOWN COUNTY STATE N/A															
22a I certify that I took charge of the remains described above, held on																							
Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																							
death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				SIGNED R. Mewilliams				TITLE (SPECIFY) M.D. DEPUTY				MEDICAL EXAMINER				DATE SIGNED 10/22/87							
EXAMINER'S NAME (TYPE OR PRINT)				DONALD R. MEWILLIAMS MD				ADDRESS				308 Gay St. Cambridge, MD 21613											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				burial 10/24/87				23b DATE				23c NAME OF CEMETERY OR CREMATORY Pk. Airey, Cambridge, Dor., Md.				23d LOCATION CITY OR TOWN COUNTY STATE							
24 FUNERAL DIRECTOR NAME				Curran Funeral Home				ADDRESS				308 High St., Cambridge, Md. 21613				25a DATE RECD BY REGISTRAR				25b REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PV-8. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

130103 OCT 29 61

20% COLLOID



067930 OCT-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

29015  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ira G. Wroten</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>1</b> YEAR <b>87</b>		2b. HOUR <b>10 P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>08</b> DAY <b>11</b> YEAR <b>08</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>79</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Md.</b>	13b. COUNTY <b>Dor.</b>	13c. CITY OR TOWN <b>Hurlock</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Glen Oak Circle 21643</b>		
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b></b> LAST <b>Wroten</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Angie</b> MIDDLE <b></b> LAST <b>unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 217-10-8697</b>		17. INFORMANT ADDRESS <b>Rt 1 Box 518</b> <b>Lettie B. Wroten Hurlock Md. 21643</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b>						
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia and CHF</b>						
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD, A.Fib</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral Brain Syndrome</b>						
19a. DATE OF OPERATION <b>10/5/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Thomas</b> MD				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>10/5/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MD. VETERANS CEM.</b>		23d. LOCATION CITY OR TOWN <b>BEULAH</b> COUNTY <b>DOR.</b> STATE <b>MD.</b>	
24. FUNERAL DIRECTOR <b>THOMAS FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 07 1987</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that medical certificates be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

087930 OCT-30

Mr. E. Whorton

Mr. E. Whorton

OCT 30 1930